DMAS was asked to develop a proposal for a Brain Injury Waiver and not submit it until funds become available. As part of that process, DMAS formed an advisory workgroup composed of representatives from various state agencies, consumers, families, advocates, and public and private providers. In addition to the requirements that must be included with every waiver, the workgroup determined that the following information should be part of the Waiver application, if one is submitted. We invite your comments on the following information. All comments will be carefully considered; however, final decisions about the waiver must rest with DMAS. We would like your comments by December 31, 2003. Comments may be submitted to Ms. Karen Lawson at klawson@dmas.state.va.us.

TARGET POPULATION: The target population for a brain injury waiver would include individuals who:

- Are between the ages of 16 and 65 when the brain injury occurred. If individuals are admitted to the BI Waiver, they could continue to receive services after turning 65 years of age if services would be appropriate;

- Are diagnosed with a brain injury that occurs after birth and is acquired through traumatic or non-traumatic insults; non-traumatic insults may include, but are not limited to anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. The definition does not include hereditary, congenital, or degenerative brain disorders, or those injuries induced by birth trauma;

- Do not have a diagnosis of mental retardation; and

- Meet the admission criteria for a nursing facility if 22 years of age or older and an Intermediate Care Facility for the Mentally Retarded (ICF/MR) if they are between 16 and 21 years of age. According to federal rules, we cannot use admission criteria for an ICF/MR for people age 22 and older.

  The alternate placements for a Virginia brain injury waiver would be nursing facilities and ICF/MRs. This means individuals would have to be evaluated for the level of care provided in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) when there is reasonable indication that an individual might need the services in the near future (that is, a month or less) unless he or she receives home or community-based services. Eligible individuals would be offered a choice of either waiver services or the alternative institutional placement.

WAIVER ENROLLMENT PROCESS/EMERGENCIES

The Workgroup established the following admission process for the Waiver:

1) Use an initial 60-day application period. Applications for the Brain Injury ("BI") Waiver will be sent to DMAS.

2) If more individuals apply than there are available waiver slots, a lottery process will be instituted to assign numbers. Any applications after the initial 60-day period will be assigned a number and served on a first-come, first-served basis.

3) All applicants will be evaluated to see if they meet level of care requirements for the BI Waiver. If they meet eligibility criteria, they will be assigned a case manager to develop a plan of care to determine to which level of care their plan will be assigned.

The Workgroup also believed that a specific number of emergencies should be served and funds to meet those emergencies should be held for that purpose. The Workgroup established the following emergency criteria:

1) The primary caregiver has a serious illness, has been hospitalized, or has died;

2) The individual has been determined by the DSS to have been abused or neglected and is in need of immediate Waiver services;

3) The individual has behaviors which present risk to personal or public safety; or

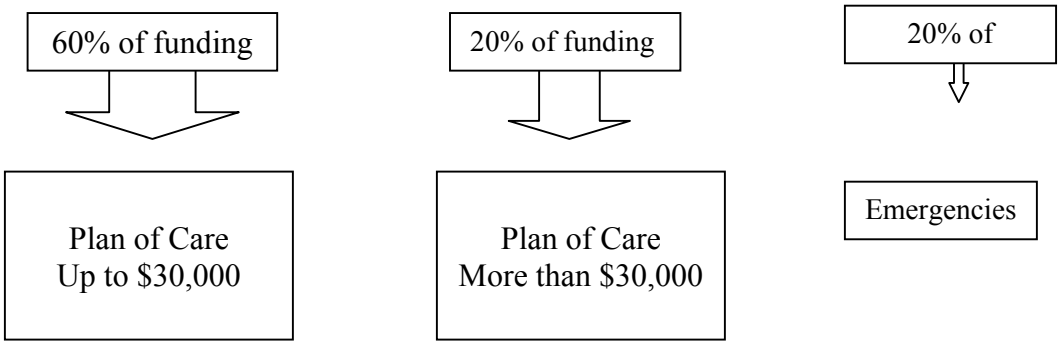
4) The individual presents extreme physical, emotional, or financial burden at home and the family or caregiver is unable to continue to provide care.

ENSURING COST EFFECTIVENESS

In order to have a waiver approved by CMS, it must be cost effective. The Workgroup decided on aggregate cost effectiveness. However, without some cost controls built into the Waiver, all funds could be directed to a small number of high cost individuals while leaving families who need some or moderate supports without services, thus increasing the likelihood that those family placements will fail and increasing the need for out-of-home placements.

There was considerable discussion in the work group about how funds allocated to this Waiver should be used. There was consensus that individuals who reside in institutions should be able to live in the community if they choose and if appropriate supports could be arranged. However, it was also recognized that individuals already living in the community whose family members have been caring for them also need supports. The Workgroup recommended using two "budget" levels and that funding be allocated for each level separately. The "budget" would be for waiver services only and would not include other Medicaid covered services, such as physician visits, hospitalization, therapies, etc. Other Medicaid services, however, must be counted toward cost-effectiveness of the Waiver. Case managers would be available to help individuals choose services. Waiting lists, if needed, would be kept separately for each level. All services available under the waiver would be available to both levels.

The Workgroup recommended that 60 percent of funds be allocated to Level One, and 20 percent of funds be allocated to Level Two in order to assure CMS that the Waiver will be cost-effective.



In compliance with CMS requirements, the budget level chosen would have to fully fund the plan of care for the individual after taking into account other community and family supports. For example, the individual could not get services from Level One and then be immediately put on a waiting list for Level Two. However, it is also recognized that family dynamics change, sometimes rapidly. Therefore, as noted abovethe remaining 20 percent would be allocated for emergencies.

POSSIBLE WAIVER SERVICES

The Workgroup developed a list of services that might be offered in a brain injury waiver. The list of possible services is below; there is no guarantee that all of these services would be offered.

- Adult companion services
- Assistive Technology
- Crisis intervention/stabilization
- Day support
- Environmental modifications
- Family/caregiver training
- Personal assistance services
- Personal emergency response services
- Prevocational services
- Residential services – (including group homes)
- Respite care services
- Skilled nursing (short term, intermittent services – this is not a long term, daily service)
- Supported employment services
- Therapeutic consultation

SERVICE PROVIDERS/LICENSURE FOR SERVICES

CMS requires that the State Medicaid agency assure there are adequate standards for each type of provider and that any applicable state licensure or certification requirements are met. DMAS will continue to work with the Workgroup to establish licensure or certification requirements for each service as appropriate.

Currently in Virginia, no State agency has the authority or the resources to license the services that may be included in a brain injury waiver. Legislative action and appropriate funds would be required to designate a State agency to fulfill licensing responsibilities for this Waiver. This waiver could not be finalized until this is done.